STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HEALTH CARE CENTER	1850 MATADOR ST PERU, IN46970

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 27, 28, 29, and 30, 2011 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN Census bed type: SNF/NF: 79 Total: 79 Census payor type: Medicare: 14 Medicaid: 49 Other: 16 Total: 79 Sample: 16 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 7/07/11 by Suzanne Williams, RN	F0000	The following of correction or any corrective action set forth herein does not constitute an admission or agreement by Caring Hands Health Care Center of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and corrective action are prepared and executed solely as provisions of Federal and State law. Caring Hands Health Care Center requests that this plan of correction be considered the facility's credible allegation of compliance. Completion Date: 07/30/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0252 SS=E	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation, interview and record review, the facility failed to ensure fans and air return ducts were clean. Two of three fans on two of three units and two air return vents on one unit were noted to have grey feathery particles. This had the potential to affect 21 of 21 residents on the West hall and 24 of 42 residents on the halls using the cafe, of a total of 79 residents in the facility. Findings include: During initial tour on 6/27/2011 at 10:35 a.m., a fan attached to the wall near the West nurse's station was observed to have grey feathery particles blowing in the breeze from the fan. The fan was blowing over the nurse's station area and bagged oxygen humidifiers. On 6/28/2011 at 11:05 a.m., the fan attached to the wall near the West nurse's station was observed to have grey feathery particles blowing in the breeze from the fan. The fan was blowing over the nurse's station area and bagged oxygen humidifiers. During environmental tour on 6/29/2011	F0252	I. The fans and air ducts identified were immediately cleaned by maintenance and housekeeping staff on 6/29/11. II. All residents are potentially affected by the alleged deficient practice. The maintenance staff began cleaning of all facility fans and air ducts on 6/29/11. III. The facility Maintenance and Environmental staff will increase the frequency of fan and air duct cleaning from a monthly schedule to a weekly inspection and cleaning as needed. Environmental and Maintenance staff will be inserviced on the new cleaning schedules and related procedures by the Maintenance Supervisor. IV. A log of fan and air vent inspections and cleaning will be maintained by the Maintenance Supervisor. The Maintenance Supervisor will present a copy of the log of inspections related to fan and air vent cleaning to the monthly QA committee meeting to ensure that cleaning schedules are being followed. Compliance concerns will be addressed by the committee on-going. V. Completion Date: 7/30/2011	07/30/2011

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	at 10:00 a.m. the fan attached to the wall near the West nurse's station was observed to have grey feathery particles blowing in the breeze from the fan. The fan was blowing over the nurse's station area and bagged oxygen humidifiers. During environmental tour on 6/29/2011 at 10:15 a.m., the ceiling fans in the cafe were noted to have dark grey feathery particles adhered to the blades of the ceiling fans. During environmental tour on 6/29/2011 at 10:50 a.m., air return vents by rooms 104 and 108 were noted to have grey feathery particles adhered to the vents. During initial tour, LPN #4 indicated 21 residents resided on the West unit. In an interview on 6/29/2011 at 3:30 p.m., Activity assistant #5 indicated there were 42 residents residing on the hall by the cafe, and approximately 24 residents used the cafe. In an interview on 6/29/2011 at 10:00 a.m., the Housekeeping Supervisor indicated the fans and vents were cleaned on a monthly basis, but should be cleaned often enough to keep dust off the fans and vents.			

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	A current monthly task list provided by the Maintenance Director on 6/29/2011 at 3:30 p.m. indicated to inspect and clean vents. In an interview on 6/30/2011 at 3:30 p.m., the Maintenance Director indicated there was no policy or further documentation regarding cleaning fans and vents. 3.1-19(f)			
F0278 SS=E	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the	F0278	I. The MDS's for Residents #6,	07/30/2011

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	facility failed to ensure 5 of 16 residents reviewed for assessments in the sample of 16 had Minimum Data Set (MDS) assessments accurately documented regarding bladder assessments, . (Residents #6, 14, 51, 53, and 75) Findings include: 1. During the initial tour of the facility, conducted on 06/27/11 between 10:45 A.M. - 11:20 A.M., RN #2 indicated Resident #6 had a supra-pubic urinary catheter. The clinical record for Resident #6 was reviewed on 06/28/11 at 8:45 A.M. Resident #6 had a physician's order, dated 04/30/10, for a suprapubic catheter due to a neurogenic bladder. The quarterly MDS assessment, completed on 06/09/11, and the MDS assessment completed due to a significant change in condition, completed on 12/18/10, indicated the resident was totally continent of his bladder. The code for indwelling catheter, 9, was not indicated. Interview on 06/28/11 during the daily exit conference, with the Regional Consultant, RN #5, who had been filling in for the MDS nurse in the facility for the		14, 51, 53, and 75 were corrected. II. All residents have the potential to be affected by the alledged deficient practice. Section H of MDS's on bladder assessments will be reviewed and any deficient MDS's will be corrected if necessary by the next scheduled MDS.III. The Interdisciplinary Team was inserviced on coding MDS's correctly. IV. The D.O.N. or designee will review 5 MDS's monthly X 3 months, then quarterly thereafter for accuracy of Section H and report monthly to the QA committee for follow-up of concerns. V. Completion Date: 07/30/2011	

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	past three months, indicated she would correct the coding error. 2. During the initial tour of the facility, conducted on 06/27/11 between 10:45 A.M. - 11:20 A.M., RN #2 indicated Resident #51 had an indwelling urinary catheter. The clinical record for Resident #51 was reviewed on 06/28/11 at 9:30 A.M. The resident was readmitted to the facility, from an acute care center, on 04/29/11 with orders for an indwelling urinary catheter due to increased pain in transferring related to cellulitis. An MDS assessment for Resident #51 was completed on 05/11/11 due to a significant change in condition. The MDS indicated Resident #51 was totally continent of her bladder. The code for indwelling catheter was not indicated. Interview, on 06/28/11 at 2:50 P.M., with RN #5, the Regional Nurse Consultant currently working as the facility's MDS coordinator, indicated she would correct the coding error regarding Resident #51's bladder continence. 3. Resident #53's record was reviewed on 6/28/2011 at 1:45 p.m. Resident #53's diagnoses included, but were not limited to, chronic kidney disease, depression, and chronic lung disease.			

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Resident #53's physician's orders dated 6/2011 indicated Resident #53 had a suprapubic catheter initially ordered 4/29/2011.

A Minimum Data Set assessment dated 5/27/2011 indicated in section H, Resident #53 had an indwelling catheter. Additionally in section H under the sub heading Urinary Incontinence, Resident #53 was indicated as occasionally incontinent. The code for indwelling catheter was not indicated.

4. Resident #75's record was reviewed 6/28/2011 at 9:45 a.m. Resident #75's diagnoses included, but were not limited to, high blood pressure, diabetes, and stroke.

Resident #75's physician's order, dated 2/2011, indicated Resident #75 had a urinary catheter ordered 1/28/2011.

A Minimum Data Set assessment dated 2/4/2011 indicated in section H, Resident #75 had an indwelling catheter. Additionally in section H under the sub heading Urinary Incontinence, Resident #75 was indicated as always continent. The code for indwelling catheter was not indicated.

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	5. Resident #14's clinical record was reviewed on 6/27/11 at 2:00 P.M.. The record indicated the resident was admitted to the facility on 10/08/09 and had diagnoses including, but not limited to, dementia and benign prostate hyperplasia. Review of resident #14's Minimum Data Set (MDS) assessment, from 12/20/10, indicated the resident was occasionally incontinent. Review of the resident's MDS of 6/16/11 indicated the resident was always incontinent. An interview with RN #3 on 6/29/11 at 9:10 A.M. indicated the MDS of 12/20/10 was incorrect for bladder continence and should have been coded differently. RN #3 indicated the resident has never been mostly continent, and she was going to make a correction to the MDS to ensure the coding was correct.. 3.1-31(h)	F0278	I. The MDS's for Residents #6, 14, 51, 53, and 75 were corrected. II. All residents have the potential to be affected by the alledged deficient practice. Section H of MDS's on bladder assessments will be reviewed and any deficient MDS's will be corrected if necessary by the next scheduled MDS.III. The Interdisciplinary Team was inserviced on coding MDS's correctly. IV. The D.O.N. or designee will review 5 MDS's monthly X 3 months, then quarterly thereafter for accuracy of Section H and report monthly to the QA committee for follow-up of concerns. V. Completion Date: 07/30/2011	07/30/2011

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F0279 SS=E	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to formulate health care plans for 5 of 16 residents reviewed for care plans in the sample of 16, for 4 residents (#14, 63, 51, 78) for toileting and 1 resident for dietary measures (#75). Findings include: 1. Resident #14's clinical record was reviewed on 6/27/11 at 2:00 P.M.. The record indicated Resident #14 had diagnoses including, but not limited to, dementia and benign prostate hyperplasia. Review of the resident's Minimum Data Set (MDS) assessment of 6/16/11	F0279	I. Care Plans were initiated for toileting on resident #14, 51, 63, and 75. Nutritional care plan for resident #78 was reviewed and updated. II. All residents have the potential to be affected by the alledged deficient practice. All care plans will be reviewed and updated as needed. III. The Interdisciplinary Team will be inserviced on initiating and completing care plans that reflect resident needs. CNA assignment sheets will be updated.IV. The D.O.N. or designee will review 5 resident's care plans monthly X 3 months, then quarterly thereafter to determine if resident's care plans reflect the resident's needs. Any concerns will be reported to the QA committee for further	07/30/2011

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	indicated the resident was always incontinent of urine. Review of the resident's health care plans on 6/29/2011 indicated the resident had no individualized health care plan for toileting. An interview with RN #3 on 6/29/11 at 1:30 P.M. indicated the resident had no individualized health care plan for scheduled toileting. RN #3 indicated staff assist all residents on resident #14's unit before or after meals and upon arising and at bedtime. 2. Resident #63's clinical record was reviewed on 6/30/11 at 8:45 A.M.. The record indicated Resident #63 had diagnoses including, but not limited to, Alzheimer's disease and anxiety. Review of the resident's Minimum Data Set (MDS) assessment of 4/20/11 indicated the resident was frequently incontinent of urine, at least 7 times in a week, but with least one episode of continent voiding. Review of the resident's health care plans on 6/29/2011 indicated the resident had no individualized health care plan for toileting.		action. V. Completion Date: 07/30/2011	

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	An interview with RN #3 on 6/29/11 at 1:30 P.M. indicated the resident had no individualized health care plan for scheduled toileting. RN #3 indicated staff assist all residents on resident #63's unit before or after meals and upon arising and at bedtime. 3. During the initial tour of the facility, conducted on 06/27/11 between 10:30 A.M. - 11:15 A.M., RN #2 indicated Resident #78 was toileted at times and at times toileted herself, though she was supposed to have supervision. The clinical record for Resident #78 was reviewed on 06/29/11 at 2:35 P.M. The most recent MDS assessment for Resident #78, completed on 04/20/11, indicated the resident had declined in bladder continency and was now frequently incontinent of her bladder. A bowel and bladder assessment, completed on 04/25/11, indicated the resident had memory issues, could identify the need to void, had no mobility or environmental issues, had dementia, had no medication or medical conditions contributing to her incontinence, and was independent for toileting needs. The assessment indicated a 3-day voiding pattern indicated the resident was continent of her bladder, but she was assessed to have "functional"			

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	incontinence. The resident was supposed to be on a prompted voiding schedule. There was no care plan regarding toileting for Resident #78. Interview with RN #2, on 06/29/11 at 1:10 P.M., indicated the resident toileted herself. The nurse was unsure of what schedule the resident should be on for the prompted voiding as the resident is able to determine when she needed to void. She additionally indicated no care plan had been initiated regarding toileting for Resident #78. 4. During the initial tour of the facility, conducted on 06/27/11 between 10:45 A.M. - 11:20 A.M., RN #2 indicated Resident #51 had an indwelling urinary catheter and was toileted on a bedside commode for bowel movements. The clinical record for Resident #51 was reviewed on 06/28/11 at 9:30 A.M. The resident was readmitted to the facility, from an acute care center, on 04/29/11 with orders for an indwelling urinary catheter due to increased pain in transferring related to cellulitis. An MDS assessment for Resident #51 was completed on 05/11/11 due to a significant change in condition. The MDS indicated Resident #51 had declined in bowel continency and was now			

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	frequently incontinent of her bowels. The previous MDS quarterly assessment, completed on 02/03/11 indicated the resident had been totally continent of her bowels. An electronic Bowel and Bladder assessment, completed on 04/29/11, indicated the only questions in the bowel assessment portion of the survey completed was the time of day and number of times in a day the resident had a BM (bowel movement). Review of the current health care plans for Resident #51 indicated there was a plan regarding the resident's potential to develop constipation, but there was no plan developed to address the resident's bowel incontinence needs. During daily exit on 6/28/2011, the DON was asked to provide any care plans regarding bowel toileting needs. None was provided. 5. Resident #75's record was reviewed 6/28/2011 at 9:45 a.m. Resident #75's diagnoses included, but were not limited to, high blood pressure, diabetes, and stroke. According to Resident #75's individual nutrition at risk record, he was admitted on 1/28/2011 having a weight of 194.4.			

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	On 3/10/2011, documentation on the nutrition at risk record indicated Resident #75's weight was 190.6 and weekly weights were discontinued. On 4/4/2011, the record indicated Resident #75's weight was 180.6, a five percent weight loss in one month. Resident #75's family and physician were notified and he was placed on weekly weights. On 4/15/2011, Resident #75's weight was 186.2 and interventions were helping improve his appetite and weight. A Minimum Data Set assessment was not completed during the time of the weight loss. A review of care plans on 6/28/2011 indicated there was no care plan initiated during the time of weight loss and no current care plan to direct or inform staff of his risk for weight loss. In an interview on 6/29/2011 at 3:30 p.m., the Minimum Data Set Coordinator indicated a care plan should have been initiated. She additionally indicated that although there was no policy for initiating care plans, the facility follows the guidelines in the Resident Assessment Instrument Manual. The Resident Assessment Instrument version 3.0 dated July 2010, indicated on			

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	page 4-2, information should be analyzed and combined to develop individualized care plans. 3.1-35(a)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to follow physician's orders regarding pressure ulcer prevention for 2 of 16 residents reviewed for physician's orders in a sample of 16. (Resident #49 and 78) Finding includes: 1. The clinical record for Resident #78 was reviewed on 06/29/11 at 2:35 P.M. The resident had a physician's order, dated 05/30/10 to "off load heels with pillows when in bed." The resident was observed on 06/29/11 at 2:40 P.M., on 06/30/11 at 9:10 A.M. and 2:40 P.M. lying in her bed. The resident had socks on her feet but her feet were noted to be lying directly on the mattress. The resident had a pillow under her head and a pillow by her head along the wall, but there was no pillow in and/or around her feet.	F0282	I. Resident #78: Resident was reassessed for risk of skin breakdown. Braden scale was completed on 07/12/11 and revealed resident was not at risk for skin breakdown. The order to offload heels with pillows when in bed was discontinued. Resident #49: The residents TAR was reviewed and updated on 6/30/11. The care plan was reviewed and updated on 6/30/11. C.N.A.'s Kardex was updated. Staff education was provided. II. All residents have the potential to be affected by the alleged deficient practice. Facility skin sweeps were completed. Braden scales will be reviewed and Risk categories identified. CNA assignment sheets updated.III. Staff will be inserviced on Wound Prevention Protocol, Interventions appropriate for each risk category identified by Braden scores, MD notification, receiving and transcribing orders. Residents current treatment orders will be reviewed and clarified as	07/30/2011

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	155702	A. BUILDING 00 B. WING	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HEALTH CARE CENTER	1850 MATADOR ST PERU, IN46970

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	A medication record, for June 2011 indicated the resident at times was documented to have refused the pillow under her heels. The resident was documented to have a pillow under her heels on the day shift on 06/29/11 though she was observed without a pillow near her feet. 2. The clinical record for Resident #49 was reviewed on 06/29/11 at 2:20 P.M. Resident #49 was admitted to the facility on 06/10/11 with a pressure ulcer on her right second toe. On 06/27/11 the resident developed a pressure ulcer on the lateral aspect of her right foot. A physician's order was received for a heel lift boot on at all times when in bed. On 06/30/11 at 9:00 A.M. and again at 10:30 A.M., Resident #49 was observed lying in bed. Her right foot and lower leg were noted to be wrapped with ace bandages and were lying directly on the mattress. At 11:30 A.M., the resident was still in bed but the occupational therapist had assisted the resident to dress. The resident still did not have a heel lift boot on her leg. At 1:30 P.M., LPN #1 indicated the heel		necessary. Care plans will be reviewed and updated. IV. D.O.N. or designee will audit all Braden scales/scores initially to identify appropriate interventions are in place for each resident, then 5 audits per month X 2 months, then quarterly thereafter. Results will be reported to the QA committee monthly and on-going for further actions needed. V. Completion Date: 07/30/2011	

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	lift boot was supposed to be on while the resident was in bed. She indicated it had been ordered on 06/27/11 and was made available at that date. Interview with the nurse consultant, RN #5, on 06/30/11 at 2:45 P.M., indicated the intervention of the heel lift boot had not been added to the care plan or the treatment record until 06/30/11.			
F0309 SS=D	3.1-35(g)(2) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interviews, the facility failed to ensure a decline in bowel continency was thoroughly assessed for 1 of 6 residents reviewed for incontinence in a sample of 16 (Resident #51). In addition, the facility failed to ensure there was thorough skin assessments for 2 of 5 residents reviewed for impaired skin in a sample of 16. (Resident #51 and 62) Findings include: 1. During the initial tour of the facility, conducted on 06/27/11 between 10:45 A.M. - 11:20 A.M., RN #2 indicated Resident #51 had an indwelling urinary	F0309	I. Resident #51: A bowel and bladder assessment was completed and a bowel program established. Also, a complete head to toe assessment by the Wound Care nurse, staff education provided on policy on wound assessments and procedure to follow when new wounds are found, as well as the procedure for skin assessments with new and re-admissions. Resident #62: A complete head to toe assessment by the Wound Care nurse, staff education provided on policy on wound assessments and procedure to follow when new wounds are found, as well as the procedure for skin assessments with new and re-admissions. II. All	07/30/2011

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	catheter and was toileted on a bedside commode for bowel movements. The clinical record for Resident #51 was reviewed on 06/28/11 at 9:30 A.M. The resident was readmitted to the facility, from an acute care center, on 04/29/11 with orders for an indwelling urinary catheter due to increased pain in transferring related to cellulitis. An MDS assessment for Resident #51 was completed on 05/11/11 due to a significant change in condition. The MDS indicated Resident #51 had declined in bowel continency and was now frequently incontinent of her bowels. The previous MDS quarterly assessment, completed on 02/03/11 indicated the resident had been totally continent of her bowels. An electronic Bowel and Bladder assessment, completed on 04/29/11, indicated the only questions in the bowel assessment portion of the survey completed was the time of day and number of times in a day the resident had a BM (bowel movement). Resident #51 also had been transferred to an acute care center on 04/24/11 due to a cellulitis infection of her lower legs.		residents have the potential to be affected by the alledged deficient practice. All residents will have a new Bowel and Bladder assessments completed within and toileting program established as indicated by the assessment. CNA assignment sheets were updated.Skin condition and pressure ulcer policies were reviewed and re-education provided. Staff re-educated on the policy to follow when new wounds are found as well as with admits and readmits. III. All nursing staff will be inserviced on Bowel and Bladder programs. Reviewed Policy/Procedure on Skin Condition and Pressure Ulcer Assessment. Staff education will be provided on the policy for skin condition and pressure ulcer assessments, frequency of skin observations by C.N.A.'s and frequency of skin assessments by licensed nurses. Nursing staff were also educated on documentation procedures for wounds. C.N.A.'s were educated on documentation and reporting new areas of skin breakdown per policy. IV. D.O.N. or designee will audit 10 Bowel and Bladder assessments monthly X 2 months, then quarterly thereafter. D.O.N. or designee will audit 5 skin assessments for accuracy weekly x 4 weeks; then 2 per week x 2 months; then quarterly thereafter. Results will be reported to the QA committee	

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	She was readmitted back to the facility, on 04/29/11 with orders for intravenous antibiotics to treat her cellulitis infection and her methicillin resistant staph infection of her lower legs. The readmission nursing assessment indicated her skin was intact, warm and dry. "Cellulitis in left leg" was documented in the cardiac portion of the readmission assessment, but there was no assessment of the resident's skin issues, especially her cellulitis. A wound care consultant documentation form, dated 04/30/11, indicated the left lower extremity was "dark red, warm, dry, taught skin over the leg." Review of nursing progress notes, from 04/29/11 - 06/29/11, indicated there was an assessment of the resident's leg documented on 05/02/11, 05/04/11, 05/05/11, 05/10/11, 05/11/11, 05/12/11, 05/19/11, 05/26/11, and on 05/29/11. On 05/12/11, a progress note at 13:31 (1:31 P.M.) indicated an order had been received to treat the residents "rashes to lower leg and thighs." There was no assessment documented of the resident's rashes. Weekly skin assessments, completed on 05/04/11, 05/11/11, 05/18/11, and 05/25/11 only indicated the resident was		monthly and on-going for further action needed.V. Completion Date: 07/30/2011	

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	receiving treatment for cellulitis but did not document an assessment of the resident's skin condition on her lower extremities. On 06/28/11 at 11:30 A.M., during interview, Resident #51 indicated she had a "horrible, painful" skin condition behind her left thigh and buttocks. She indicated she was going to a wound doctor that evening for an appointment. She indicated she had been experiencing the condition for at least a week but no one had done much for the issue. On 06/30/11 at 10:00 A.M., Resident #51's skin was observed. The resident was noted to be obese with multiple leg rolls. The skin on both of the resident's legs were noted to be shiny and tight. Most of the resident's left lower leg from just below the knee to the top of the foot was noted to be reddened. There was also a red area, larger than a foot ball noted on the inner aspect of the resident's left thigh. There were three walnut to baseball sized red areas on the resident's right leg. The resident's posterior thigh was partially examined and a large 12 inch by 10 inch rectangle of red, excoriated skin was noted to cover most of her posterior thigh. The resident declined to fully roll over so the buttock and all of the perineal area could not be fully viewed. The resident			

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	indicated the excoriated area extended to her buttock area. A skin assessment, completed on 06/29/11 indicated the following skin issues: "abrasions: medial - 4.0 by 6.0 red tissue with scant serous drainage, lateral 7.0 by 2.5 red tissue with scant serous drainage. periwound red., left buttocks 6.0 by 3.0 red tissue, scant serous drainage, periwound red, right buttocks 2.0 by 3.5 area not open at this time." A skin assessment from the wound nurse practitioner, undated, but completed on 06/28/11 indicated the following assessment: "pt has new skin abrasion sheer damage bilateral buttocks...." There was no further thorough skin assessment completed for Resident #51. 2. Resident #62's record was reviewed 6/27/2011 at 2:45 p.m. Resident #62's diagnoses included, but were not limited to, bipolar disorder, stroke, and seizures. During a skin observation on 6/29/2011 at 11:20 a.m., LPN #1 indicated Resident #62 had developed a stage II pressure area on his left foot close to his little toe, despite interventions of frequent turning and positioning, pressure reduction mattress and a pressure reduction boot. The area measured 0.8 x 1.6 x less then			

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	0.1. the area showed pink wound base without drainage. LPN #1 further indicated the wound was discovered on 6/28/2011. A review of CNA skin checks revealed a skin check was completed on 6/17 and 6/21. There was no indication a skin check had been completed on 6/24/2011. In an interview on 6/30/2011 at 2:36 p.m., RN #3 indicated nurses were to perform weekly and CNAs perform as needed skin checks. Staff would be alerted and orders and treatments initiated. In an interview on 6/30/2011 at 2:37 p.m., the Director of Nursing indicated a skin check should have been completed on 6/24/2011. A current policy dated 10/10 titled Skin Condition and Pressure Ulcer Assessment indicated "...1. All residents...will have a body check ... by a licensed nurse at least weekly...4. Skin observations are made daily...." 3.1-37(a)			

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F0315 SS=E	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure thorough bladder assessments were completed for 4 of 6 residents reviewed for incontinence in a sample of 16. (Residents #14, 49, 63, and 78) Findings include: 1. During the initial tour of the facility, conducted on 06/27/11 between 10:30 A.M. - 11:15 A.M., RN #2 indicated Resident #49 was new to the facility, was confused, currently received an antibiotic for a urinary tract infection, was incontinent of her bladder, and was toileted. The clinical record for Resident #49 was reviewed on 06/29/11 at 2:20 P.M. The resident had been admitted to the facility on 06/10/11. The initial Minimum data set (MDS) assessment, completed on 06/20/11	F0315	I. Bladder assessments were completed for residents #14, 49, 63, and 78- based on voiding diary. Toileting program was established based on assessment and care plans were implemented. II. All residents have the potential to be affected by the alleged deficient practice. All residents will have new bowel and bladder assessments completed and toileting program established as indicated by the assessment. Care plans for toileting will be implemented. CNA assignment sheets updated. III. All nursing staff will be inserviced on bowel and bladder programs. IV. D.O.N. or designee will audit 10 bowel and bladder assessments, toileting programs, and related care plans monthly X 2 months, and then quarterly thereafter to verify compliance. Any concerns will be reported to the QA committee for further action. V. Completion Date: 07/30/2011	07/30/2011

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	indicated the resident was frequently incontinent of her bladder. The bowel and bladder assessment, completed on 06/24/11, for Resident #49 indicated only the resident's congestive heart failure, edema, and dementia diagnosis were considered, and the resident's use of diuretics and narcotics, and mobility limitations were not considered in regard to the resident's bladder incontinence. The treatment plan was to check and change the resident, even though the bladder voiding diary, completed on 06/15, 06/16, and 06/17 indicated she could be continent of her bladder when toileted. 2. During the initial tour of the facility, conducted on 06/27/11 between 10:30 A.M. - 11:15 A.M., RN #2 indicated Resident #78 was toileted at times and at times toileted herself, though she was supposed to have supervision. The clinical record for Resident #78 was reviewed on 06/29/11 at 2:35 P.M. The most recent MDS assessment for Resident #78, completed on 04/20/11 indicated the resident had declined in bladder continency and was now frequently incontinent of her bladder.			

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A bowel and bladder assessment, completed on 04/25/11, indicated the resident had memory issues, could identify the need to void, had no mobility or environmental issues, had dementia, had no medication or medical conditions contributing to her incontinence, and was independent for toileting needs. The assessment indicated a 3 - day voiding pattern indicated the resident was continent of her bladder but she was assessed to have "functional" incontinence. The resident was supposed to be on a prompted voiding schedule.

However, there was no care plan regarding toileting for Resident #78. Interview with RN #2, on 06/29/11 at 1:10 P.M. indicated the resident toileted herself. The nurse was unsure of what schedule the resident should be on for the prompted voiding as the resident is able to determine when she needed to void.
3. Resident #14's clinical record was reviewed on 6/27/11 at 2:00 P.M.. The record indicated Resident #14 had diagnoses including, but not limited to, dementia and benign prostate hyperplasia.

Review of the resident's Minimum Data Set (MDS) assessment of 6/16/11 indicated the resident was always incontinent of urine.

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	Review of scheduled toileting log from 6/14/11 through 6/27/11 indicated the resident was often continent when toileted 5 times each day Review of the resident's health care plans indicated the resident had no individualized health care plan for toileting. An interview with RN #3 on 6/29/11 at 2:45 P.M. indicated the resident had not been assessed for voiding patterns with a 3 day voiding assessment. 4. Resident #63's clinical record was reviewed on 6/30/11 at 8:45 A.M.. The record indicated the resident was admitted to the facility on 8/1/06 and had diagnoses including, but not limited to, Alzheimer's disease and anxiety. Review of the resident's Minimum Data Set (MDS) assessment of 4/20/11 indicated the resident was frequently incontinent of urine, at least 7 times in a week, but with least one episode of continent voiding. Review of the resident's health care plans indicated the resident had no individualized health care plan for toileting.			

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	155702	A. BUILDING 00 B. WING	06/30/2011

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	An interview with RN #3 on 6/30/11 at 2:00 P.M. indicated the resident had not been assessed for voiding patterns with a 3 day voiding assessment. Review of the facility policy and procedure "Bowel and Bladder Assessment" revised November 2008, indicated: "Times: 1. On all residents at time of admission. 2. Development of incontinence. 3. Evaluate the use of, or removal of urinary catheter. 4. Bladder retraining or incontinence management. Under "Additional: 1. Residents identified with the capacity of improved functioning-a three day voiding diary/assessment will be conducted to identify voiding patterns and response to prompting." Under "Procedure: 1. Initiate 3-day voiding diary on Admission." Under "Rationale. 1. Resident should be checked at least every two hours for incontinence and will be toileted, if dry and as needed. 8. Analyze information/patterns and determine whether retraining or incontinence management program by toileting schedule is to be utilized. 9. Initiate individual or facility toileting plan. If individual plan, complete the form with residents to determine the toileting schedule. 10. File the three-day diary in medical record."			

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	3.1-41(a)(1)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure 1 of 7 residents (#44) reviewed for psychotropic medications had adequate indications for increasing a psychotropic medication, in a sample of 16. In addition, the facility failed to ensure 2 of 7 residents (#44, 62) reviewed for psychotropic medications had proper monitoring of side effects, in a sample of 16. Findings include:	F0329	I. Resident #44: MD was contacted and medications reviewed. All mood/behaviors in last 30 days reviewed for new or worsening behaviors. Care plan reviewed and updated. Resident's last AIMS was completed 01/28/11 with a score of "1." MDS significant change was effective 02/03/11. Staff education provided on performing AIMS, and assessment updated. Resident #62: Resident's last AIMS was completed on re-admit	07/30/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1a. Resident #44's clinical record was reviewed on 6/30/11 at 10:55 A.M.. The record indicated the resident was admitted to the facility on 1/27/11 and had diagnoses including, but not limited to, dementia with behaviors and anxiety. The resident medications included, but were not limited to: Haloperidol (antipsychotic medication) 0.5 milligrams (mg) at bedtime: Lexapro (antidepressant medication) 20 mg daily; Clozapine (antipsychotic medication) 50 mg at bedtime. Review of resident #44's physician's orders indicated on 5/24/11 the resident's Clozapine was increased from 37.5 mg at bedtime to 50 mg at bedtime. Review of resident's health care plan initiated on 9/2/10 indicated: "Focus: Resident has history of yelling, threatening, being anxious, and being nervous related to dementia with behaviors. She takes Haldol and Clozaril for diagnosis and behaviors associated with behaviors. Resident also receives ECT treatments as ordered by physician."; "Goals: Resident will accept staff interventions when displaying signs or symptoms through next review."; "Interventions: Take resident to quiet/calm environment to decrease		from Generations Behavioral Unit on 04/14/11. Staff education provided on performing AIMS, and assessment updated. II. All residents receiving anit-psychotic medications are potentially affected by the alleged deficient practice. Psychopharmacological review has been performed identifying all residents receiving anti-psychotic therapy. AIMS assessments were reviewed on all residents receiving anti-psychotic therapy. Staff education was provided and all assessments updated. Care plans were reviewed and updated as appropriate. III. Staff in-serviced over mood/behavior program. Social Services consultant in-serviced SSD regarding policy for Mood/Behavior program and Psychotropic medication program. Behaviors/moods are reviewed during morning meeting 5 days a week. Physician orders for psychotropic medications are reviewed by the DON. Reviewed Policy/Procedure on AIMS Side Effect Monitoring. Staff education was provided on mood/behavior program and AIMS testing. Further education was providing on performing an AIMS assessment, purpose of the assessment, and the meaning of the results. After education, all residents received a new assessment. IV. The D.O.N. or designee will perform monthly behavior and anit-psychotic	

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	155702	A. BUILDING 00 B. WING	06/30/2011

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	behavior; Allow resident time to vent concerns/feelings; Validate residents concerns/feelings; Offer activities of residents liking; Monitor of unmet needs; Meds as ordered; Document and inform social services as necessary." Review of the resident's "mood/behavior report sheets" provided by the facility prior to the Clozapine increase on 5/24/11 indicated: On 5/13/11 indicated the resident was pacing and was obsessive with clothes and laundry. The intensity of the behavior was mild. The intervention used was took for walk, stroll, activity. The outcome was behavior decreased; On 5/16/11 the mood/behavior was mad about hearing aid battery. No intensity or interventions or outcome were documented On 5/23/11 the resident made repetitive verbalizations, was anxious about meals, medicine, phone not working, pacing up and down hall to nurse's station from room. The intensity was moderate. Interventions used were talked to resident and offered snack, drink. The outcome was behavior decreased, behavior stopped, resident calm. On 5/25/11 the resident made repetitive verbalizations, repetitive questions, was anxious and confused to time. The intensity was moderate. Interventions used were talked to resident and took for walk, stroll, activity. The		medication reviews, along with AIMS assessments and scores for accuracy and follow-up. Results will be reviewed monthly by the interdisciplinary team-made up of Social Service, D.O.N., and consulting Pharmacist. Results will be reported to the QA committee monthly and on-going for further action as needed. V. Completion Date: 07/30/2011	

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	outcome was behavior stopped. Review of "behavior data collection tool" from 5/19/11 indicated: "Resident wanting more medication, stating that she gets 8 pills on days and that I need to give her 8 pills to when she only gets 5. She continuously obsesses over this and refuses redirection. I call Dr.'s office and left a voice mail asking them to reevaluate her for more ECT." An interview the Social Service Director (SSD) on 6/30/11 at 3:30 P.M. indicated when resident makes anxious complaints interventions are short lived then complaints return. 1.b. Resident #44's clinical record was reviewed on 6/30/11 at 10:55 A.M.. The record indicated the resident was admitted to the facility on 1/27/11 and had diagnoses including, but not limited to, dementia with behaviors and anxiety. The resident medications included, but were not limited to: Haloperidol (antipsychotic medication) 0.5 milligrams (mg) at bedtime: Lexapro (antidepressant medication) 20 mg daily; Clozapine (antipsychotic medication) 50 mg at bedtime. Review of resident #44's physician's orders indicated on 5/24/11 the resident's			

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	Clozapine was increased from 37.5 mg at bedtime to 50 mg at bedtime. Resident #44 had an Abnormal Involuntary Movement Scale (AIMS) completed on 1/28/11 to monitor side effects related to psychotropic medication. An interview with the DON on 6/30/11 at 3:35 P.M. indicated no new AIMS was completed after the increased in Clozapine on 5/24/11. 2. Resident #62's record was reviewed 6/27/2011 at 2:45 p.m. Resident #62's diagnoses included but were not limited to bipolar disorder, stroke, and seizures. A review of Resident #62's physician's orders dated 6/10/11 indicated Resident #62 had been receiving Thorazine and Lamictal, psychotropic medications requiring monitoring. A test for involuntary movements (AIMS) dated 10/5/2010 indicated no involuntary movements were noted at that time. There was no further testing documented on the chart. In an interview on 6/30/2011 at 2:37 p.m., the Director of Nursing indicated no further testing was able to be found. She further indicated testing should have been completed in April.			

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	A current policy dated 11/2004 titled AIMS-Side Effect Monitoring indicated "...7. AIMS testing will be completed every 6 months and when there has been a significant change...." 3.1-48(a)(3) 3.1-49(a)(4)			
F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure ice was handled to prevent contamination. This had the potential to affect 19 of the 21 residents residing on the West hall., of a total of 79 residents residing in the facility. Findings include: During an observation on West hall on 6/27/2011 at 11:57 a.m., CNA #6 opened the ice container and placed the lid of the container inside down on the nurse's station desk while removing ice from the container to serve residents. She then replaced the lid on the container without sanitizing the lid.	F0371	I. A replacement ice chest with an attached lid has been placed into use for ice passing. All staff was inserviced on the policy for proper passing of fresh water and ice. II. All resident have the potiential to be affected by the alleged deficient practice. All staff have been inserviced on the policy for proper passing of fresh water and ice. III. The policy/procedure for passing fresh water and ice was reviewed. A new ice chest with attached lids were placed into use and all staff were inserviced on policy. IV. D.O.N. or designee will audit fresh water/ice passing 5 times per week X 4 weeks; then 2 times per week X 2 months; then quarterly thereafter. Results will be reported to the QA committee monthly and on-going for futher action as necessary. Completion	07/30/2011

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	During an observation on 6/27/2011 between 5:02 and 5:21 p.m., the ice container lid remained open. During this time, CNA #7 withdrew ice at 5:02 p.m., CNA #8 at 5:10 p.m., and LPN #9 at 5:13 p.m., during meal tray pass to give to residents. In an interview on 6/27/2011 at 5:30 p.m., the Dietary Manager indicated the ice should be covered between times when it is not being utilized. A current policy dated 4/2005, titled passing fresh water, indicated "...cover ice chest/container...." 3.1-21(i)(3)		Date: 07/30/2011	